



MaineCare Services

An Office of the
Department of Health and Human Services

Department of Health and Human Services
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John E. Baldacci, Governor

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TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: MaineCare Benefits Manual, Section 45, Hospital Services, Chapter II

DATE: September 22, 2009

This letter gives notice of adopted rule: Chapter 101, MaineCare Benefits Manual, Chapter II, Section 45, Hospital Services.

The Department of Health and Human Services (the "Department") is permanently adopting Section 45, Chapter II emergency rules currently in place with some changes. These rules clarify admission eligibility and continuing eligibility criteria for hospital psychiatric unit services and require hospital reporting of additional rebatable physician administered drugs effective January 1, 2010, and requires reporting of all rebatable physician administered drugs effective upon implementation of MaineCare's new claims system, MIHMS.

The Department needs to ensure that MaineCare services are delivered only to individuals who are eligible for those services. These rules clarify admission eligibility and continuing eligibility criteria for hospital psychiatric unit services. These changes assure the efficient operation of the MaineCare program by ensuring that only individuals who are eligible receive the service. Further, the administrative burden of utilization review is lessened if the admission and continuing eligibility criteria are clear from the beginning.

The Department is not removing Katie Beckett eligibility criteria from this section as originally proposed. There are no changes in Katie Beckett eligibility in this rulemaking. Consolidating the Katie Beckett eligibility into one section, as originally intended, will not happen at this time.

These adopted rules also incorporate a requirement that hospitals report additional rebatable physician administered drugs by NDC beginning January 1, 2010 in order to meet FY 2010 budget savings.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or, for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at 624-7539, option 8 or 1-800-321-5557, extension option 8 or TTY: (207)287-1828 or 1-800-423-4331.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Section 45, Hospital Services, Chapter II – FINAL RULE

ADOPTED RULE NUMBER:

CONCISE SUMMARY: These adopted rules establish admission eligibility and continuing eligibility criteria for hospital psychiatric unit services. These changes will assure the efficient operation of the MaineCare program by ensuring that only individuals who are eligible receive the service. Further, the administrative burden of utilization review will be lessened if the admission and continuing eligibility criteria are clear from the beginning. These rules also require reporting of additional physician administered rebatable drugs.

See http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.htm for rules and related rulemaking documents.

EFFECTIVE DATE: September 28, 2009

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45.01 | **DEFINITIONS**

- 45.01-1 **Hospital** means a hospital licensed by the Department of Health and Human Services in Maine, or appropriate licensing agencies in the state where the hospital is located, and qualified to participate in the Medicare Program.
- 45.01-2 **Inpatient** means a patient who has been admitted to the hospital and is receiving room, board and professional services in the hospital on a continuous twenty-four (24) hour-a-day basis.
- 45.01-3 **Outpatient** means a patient who is receiving professional services at a licensed hospital, or distinct part of such hospital, which is not providing the patient with room, board and professional services on a continuous twenty-four (24)-hour-a-day basis. An outpatient is an individual who has not been admitted to the hospital for an overnight stay.
- 45.01-4 **Utilization Review/Management** means the evaluation of the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities by each participating hospital. It includes a review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices.
- 45.01-5 **Swing-Bed** means a federally certified hospital bed that may be used interchangeably as an acute care bed or a skilled nursing facility (NF) bed as defined in Chapter II, Section 67 of this Manual.
- 45.01-6 **Authorized Agent** means an organization authorized by the Department to perform functions pursuant to these rules under a valid contract or other approved, signed agreement.
- 45.01-7 **Critical Access Hospital** means a hospital licensed by the Department as a critical access hospital.
- 45.01-8 **Day(s) Awaiting Nursing Facility (NF) Placement** means any day on which a hospital provides services to an inpatient that would constitute post-hospital nursing facility services if provided by a nursing facility,
- (1) if that day falls after a quality assurance or utilization review process has determined that inpatient hospital services for the individual are not medically necessary;
 - (2) if post-hospital nursing facility services are not otherwise available to the individual (as described in Section 45.07-2); and

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45.01 **DEFINITIONS (cont.)**

- (3) that the Department or its Authorized Agent has determined is medically eligible for nursing facility services as described in Chapter II, Section 67, of this Manual.

45.01-9 **340B Hospital** means a hospital eligible to participate in the federal 340B Drug Pricing Program administered by the U.S. Department of Health and Human Services Health Resources and Services Administration. Currently, only hospitals that may also receive disproportionate share may participate in the 340 Drug Pricing Program. Information about 340 B participation is at: <http://www.hrsa.gov/opa/introduction.htm>.

45.02 **ELIGIBILITY FOR CARE**

Members must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

It is the provider's responsibility to verify a member's MaineCare eligibility as described in MBM, Chapter I, prior to providing services.

45.03 **DURATION OF CARE**

All hospital admissions and continued stays must be certified for medical necessity and length of stay through an appropriate utilization review plan.

45.04 **COVERED SERVICES**

45.04-1 **Semi-Private Accommodations**

Reimbursement will be made for eligible members for placement in semi-private accommodations (two (2) or more beds).

45.04-2 **Intensive Care or Coronary Care**

Accommodations in an intensive care unit or a coronary care unit are reimbursable if ordered by the patient's physician as medically necessary.

45.04-3 **Drugs and Biologicals**

A. **Drugs and Biologicals**

Drugs, vaccines, cultures, and other preparations made from living organisms and their products, used in diagnosing, immunizing, or treating members

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45.04 COVERED SERVICES (cont.)

(biologicals) are covered. Drugs and biologicals furnished by a hospital for a patient's use outside of the hospital are not covered as inpatient services.

B. Hospital Pharmacies Affiliated with a Nursing Facility

A hospital that is affiliated with a nursing facility through common ownership or control is allowed to dispense covered MaineCare prescription drugs through its pharmacy to members in that nursing home. The drugs must be dispensed by a registered pharmacist according to dispensing regulations.

Billing must be accomplished in accordance with MBM Section 80, Pharmacy Services, and Section 67, Nursing Facility Services.

45.04-4 Supplies, Appliances and Equipment

Supplies, appliances and equipment are covered if they are surgically implanted or are an integral part of a hospital procedure and it would be medically contraindicated to limit the patient's use of the item to his or her hospital stay (e.g.: cardiac valves, pacemakers, tracheotomy tubes, halovests, titanium rods, etc.).

A temporary or disposable item that is medically necessary to facilitate the patient's discharge from the hospital, and is required until the patient can obtain a continuing supply, is covered as an inpatient service for up to a ten (10) day supply.

Except as noted above, supplies, appliances, including prosthetic devices, and equipment furnished to an inpatient or outpatient for use outside of the hospital must have prior authorization in accordance with and meet criteria in Chapter II, Section 60, Supplies and Durable Medical Equipment, of this Manual, and reimbursement must be made to a supplier of durable medical equipment. MaineCare will not reimburse a hospital or supplier of durable medical equipment for the rental or purchase of a therapy bed (specialty air beds built into a hospital bed frame).

45.04-5 Ancillary, Diagnostic and Therapeutic Services

Ancillary, diagnostic and therapeutic services that are medically necessary are covered services subject to limitations in Section 45.05.

45.04-6 Swing-Bed and Days Awaiting Placement Services

The provision of acute care services to a member in a swing-bed must be consistent with requirements set forth in this Section of the Manual.

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45.04 COVERED SERVICES (cont.)

NF swing-bed and days awaiting placement services must meet all state and federal laws, including federal Medicaid laws and regulations and the Nursing Facility Services requirements set forth in Section 67 of this Manual, and members must be eligible for NF level of services as determined by an assessment conducted by the Department or its Authorized Agent. Members in swing-bed and days awaiting placement are exempt from both: i) pre-admission screening for mental illness and mental retardation; and ii) Minimum Data Set + (MDS+) resident assessment screening.

45.04-7 Asthma Self-Management Services

Asthma self-management services are reimbursable if they are based on the Open Airways or Breathe Easier curricula or any other asthma management services that are approved by the National Heart, Lung and Blood Institute/American Lung Association or the Asthma and Allergy Foundation of America.

Each service must have:

- A. a physician advisor;
- B. a primary instructor (a licensed health professional or a health educator with a baccalaureate degree);
- C. a pre and post assessment for each member that shall be kept as part of the member's record;
- D. an advisory committee that may be part of an overall patient education advisory committee; and
- E. a physician referral for all participants.

45.04-8 Outpatient Diabetes Education and Follow-Up Services

Outpatient Diabetes Education and Follow-Up Services will be reimbursed when a provider enrolled with the Maine Diabetes Control Project furnishes this service to a MaineCare member whose physician or primary care provider has prescribed this service for the management of the member's diabetes. The services consist of:

- 1. A pre-assessment interview determining the member's knowledge, skills and attitudes about diabetes management and to develop an individualized education plan and behavior change goals;

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45.04 COVERED SERVICES (cont.)

2. A group class instruction covering the comprehensive curriculum outlined by the Maine Diabetes Control Project and based on the individualized education plan;
3. A meal planning interview to determine the member's knowledge, skills and attitudes about meal planning and to develop an individualized meal plan and behavior change goals;
4. A post service interview to assess and document what the member has learned during the service, and to develop a plan for follow-up sessions to address the component areas not learned in the class series, and finalize behavioral goals; and
5. Follow-up contacts to reassess and reinforce self-care skills, evaluate learning retention and progress toward achieving the member's behavior change goals. At a minimum, three (3) month, six (6) month, and one (1)-year follow-up visits (from the date of the last class) are required to complete the member's participation in the service. When the MaineCare member is under age twenty-one (21), MaineCare will also reimburse for this service when provided to the people who provide the member's daily care.

45.04-9 Hospital Based Physician Services

Effective July 1, 2006, only provider practices that qualify as "provider-based" entities under 42 C.F.R. § 413.65 are covered services.

45.05 RESTRICTED SERVICES

45.05-1 Whole Blood and Packed Red Blood Cells

Each eligible member may receive as many pints of whole blood and packed red blood cells as are medically necessary.

In the case of a MaineCare member who is also receiving Title XVIII benefits, MaineCare will pay for the first three pints of blood, not covered under Title XVIII. Whole blood (provided the hospital cannot obtain a replacement donation) and packed red blood cells will be reimbursable only for each pint administered. Reimbursement will not be made on the basis of replacing two pints of blood for each pint received by the member regardless of whether the blood (either fully or partially) is provided from a blood bank or from a donor.

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45.05 RESTRICTED SERVICES (cont.)

45.05-2 Newborn Infants

MaineCare reimburses for services provided to newborn infants of MaineCare mothers during the time the mother is hospitalized. MaineCare will pay for services to the newborn after the mother is discharged, if these services are certified by the physician as being medically necessary and the infant is MaineCare eligible.

45.05-3 Abortions, Sterilizations and Hysterectomies

MaineCare will only reimburse hospitals for these services if documentation meets the requirements of Chapter II, Section 90, Physician Services.

45.05-4 Dental Services

Dental services provided in a hospital setting are only covered for emergency care.

45.05-5 Private Rooms for Patients with Infectious Diseases

MaineCare will reimburse for private rooms for patients with infectious diseases when medically necessary to meet the patient's medical needs or to prevent the spread of disease.

The designee of the committee charged with infection control must document the medical necessity in the patient's medical record. The designee must formally inform the committee of his or her decisions regarding assigning private rooms to patients with infectious disease. The committee must record the designee's actions in its minutes.

45.05-6 Restricted Physician Services Associated With Hospital Services

Unless prior authorization (PA) has been granted by the Department, DHHS will not reimburse hospitals for costs associated with any restricted physician services performed in the hospital, as noted in Chapter II, Section 90, Physician Services, of this Manual.

45.05-7 Organ Transplant Procedures

Please refer to Chapter II, Section 90, Appendix A, Physician Services of this Manual for specific information related to MaineCare coverage of and criteria for transplant procedures.

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45.05 RESTRICTED SERVICES (cont.)

45.05-8 Leave of Absence- Days Awaiting Nursing Facility Placement

All hospitals must inform patients who are in days awaiting NF placement, in writing, of their right to thirty-six (36) overnight leaves of absence as outlined in the MaineCare Benefits Manual, Chapter II, Section 67.05. MaineCare will reimburse a hospital to reserve a bed for a member on an overnight leave of absence if the following conditions are met:

- A. The patient's plan of care provides for such an absence;
- B. The member takes no more than a total of thirty-six (36) days in leaves of absence during the twelve (12) month period from July 1 through June 30, with no more than three (3) days occurring each calendar month;
- C. The Department is called for prior authorization; and
- D. The Department is notified if the member does not return to the facility within the prior authorized leave period.

45.05-9 Outpatient Observation Services

MaineCare only reimburses for observation or testing when ordered by a physician. Outpatient observation must not exceed forty-eight (48) hours.

45.05-10 Physical, Occupational and Speech Therapy for Adults

Physical, occupational and speech therapy for members age twenty-one (21) and over must be provided in accordance with Section 68, Occupational Therapy Services; Section 85, Physical Therapy Services; and Section 109, Speech and Hearing Services, respectively, including any limitations or requirements for rehabilitation detailed in those Sections of the MBM.

45.06 NON-COVERED SERVICES

45.06-1 Private Room

Accommodations in a private room will not be reimbursable unless they meet conditions spelled out in Section 45.05-5 above.

Hospitals may not bill a MaineCare member for the difference between a private room rate and a semi-private room rate unless the member requests a private room and signs a written statement acknowledging that he or she is to be billed the difference.

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45.06 NON-COVERED SERVICES (cont.)

45.06-2 Routine Physician Visits

Routine physician visits are not reimbursable for members awaiting placement in a NF or in swing beds.

45.06-3 Admission Not Certified By Utilization Review

MaineCare will not reimburse for a hospital admission that is not certified by a utilization review.

The only exception to this policy is when a member is admitted prior to utilization review for an acute condition that requires medically necessary treatment that is only available in a hospital and it is medically necessary for the treatment to be delivered prior to the time it feasible for the case to be reviewed. Services rendered prior to the review are not reimbursable unless the utilization review is conducted within one (1) business day of the admission. (For example, if a member is admitted on a Friday at 6:00 P.M., is first reviewed on Monday at 11:00 A.M. and denied at that time: three (3) days are reimbursable.) The member or responsible party must be notified in writing if these criteria will not be met and all or part of the admission will not be a MaineCare covered service; and must sign an acknowledgement of financial responsibility for this non-covered service.

45.06-4 Unauthorized Days Awaiting Placement or NF-level Swing Bed Services

MaineCare will not reimburse for any days awaiting placement or NF level services providing swing beds that have not been approved by the Department or its Authorized Agent.

45.07 POLICIES AND PROCEDURES

45.07-1 Discharge Planning

Medicaid patients denied continued hospitalization as a result of utilization review, or denied Medicare or other third party coverage on the basis of no longer having medical necessity for hospitalization, shall be denied Medicaid coverage unless approved for days waiting NF placement, as described in Section 45.07-2. A copy of the denial letter indicating the last day of third party coverage must be submitted to the Department.

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45.07 POLICIES AND PROCEDURES (cont.)

Each hospital shall maintain a written record of discharge planning procedures, setting forth at least the following:

- A. The name of the staff member of the hospital who has operational responsibility for discharge planning.
- B. The manner and methods by which such staff member will function, including his or her authority and relationship with the facility's staff.
- C. The time period in which each eligible individual's need for discharge planning will be determined (which period may not be later than seven days after the day of admission).
- D. The local agencies and individuals available to the facility as discharge planning resources, and a requirement that the attending physician assist a multidisciplinary team in developing discharge plans. Responsibilities for implementation shall be a team decision.
- E. A provision for periodic review and re-evaluation of the facility's discharge planning program.

45.07-2 Medical Eligibility Determination for Nursing Facility (NF) Care

Prior to discharge, the hospital must notify members who will require nursing facility care services that a preadmission long-term care assessment is required for each applicant, regardless of source of payment, including private pay individuals. The Department or its Authorized Agent shall conduct the assessment using the approved eligibility assessment form. For a member transferring from a hospital to a NF under Medicare or any other private insurance coverage, the long-term care assessment may be delayed until the exhaustion of his or her insurance covered NF stay. To receive MaineCare coverage for days awaiting placement, or nursing facility level services, a member must meet the medical eligibility requirements as set forth in Chapter II, Section 67.

When it is expected that a patient will convert from Medicare, private pay or other third party coverage to MaineCare coverage, the hospital, on behalf of the member, must request a nursing facility eligibility assessment prior to the exhaustion of the individual's current coverage. The Department or Authorized Agent must conduct this assessment when these third party benefits are exhausted. In the cases of Medicare denials, a copy of the hospital's Medicare denial letter, indicating the last day of covered services, must be submitted to the Department or its Authorized Agent.

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45.07 POLICIES AND PROCEDURES (cont.)

General Procedures for Medical Eligibility Determination

Eligible members who no longer require acute care and are to be transferred from a hospital to a NF, skilled NF level swing-bed, or days waiting NF placement status must be determined medically eligible, pursuant to the criteria set forth in Chapter II, Section 67 of this manual, by the Department or its Authorized Agent, prior to this transfer.

An individual may be admitted directly to a skilled NF level swing-bed without prior acute inpatient services, if determined medically eligible by the Department or its Authorized Agent.

1. The hospital shall request an assessment by submitting a complete referral form to the Authorized Agent. An incomplete form will be returned to the hospital and the assessment delayed until receipt of a complete form. Forms may be faxed. The Authorized Agent shall complete the medical eligibility assessment form within twenty-four (24) hours of the request for an assessment and the eligibility assessment shall not be conducted sooner than twenty-four (24) hours prior to the denial of acute level of care or discharge from a hospital.
2. If the patient is not a MaineCare member, the hospital's discharge planner or other designated person shall explore MaineCare eligibility and refer the patient, family member or guardian to the Office of Integrated Access and Support.
3. The hospital's discharge planner or other designated person must request that the Department or its Authorized Agent complete the eligibility assessment forms as specified in Chapter II, Section 67 of this Manual.
4. The Department or its Authorized Agent will inform the member and offer the choice of available, appropriate and cost-effective, home and community-based services and alternatives to NF placement. The relative costs to the member of each option must be explained.

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45.07 POLICIES AND PROCEDURES (cont.)

5. If the member does not select community-based services, he/she must accept the first available, appropriate nursing facility placement within a sixty (60)-mile radius of his/her home, or MaineCare reimbursement will cease. If the member refuses to accept the placement, the hospital discharge planner must notify the Department. The Department will issue a ten (10) day notice of intent to terminate services. The member may accept a placement beyond the sixty (60) miles from home radius, however, this cannot be required of the member.

The discharge planner shall document in the medical record all efforts to obtain appropriate placement.

6. If the member is eligible for both MaineCare and Medicare and is eligible for Medicare nursing facility services, the member shall be admitted to a Medicare-certified NF bed, except in the following circumstances:
 - a. The member has been a resident in a NF and desires to return to that NF and can receive appropriate care; or
 - b. An appropriate Medicare-certified NF bed is not available within a sixty (60)-mile radius of the member's home.

Once a NF bed is secured, the hospital must notify the Department or its Authorized Agent, on the approved form, of the member's placement.

7. Prior to a member's return to a NF, following a hospital stay that exceeds bed hold limitations in Chapter II, Section 67, the member must be assessed by the Department or its Authorized Agent using the medical eligibility determination form to determine whether he/she continues to meet the medical eligibility criteria set forth in Chapter II, Section 67 for NF services, and whether or not community-based services are an appropriate option.
8. When a member is found financially eligible retroactively, MaineCare will reimburse for covered services that the hospital provides only during the period for which the member has been found to be both medically and financially eligible.

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45.07 POLICIES AND PROCEDURES (cont.)

45.07-3 Program Integrity

Program Integrity monitors the services provided and determines the appropriateness and necessity of services. See Chapter I for further information.

45.08 | ELIGIBILITY FOR HOME CARE FOR CHILDREN ELIGIBLE THROUGH THE KATIE BECKETT BENEFIT

The following criteria must be met for children to be eligible for home care through the Katie Beckett benefit:

A. Age and Disability

The child must be eighteen (18) years of age or younger and be determined disabled under SSI rules. The Medical Review Team (MRT) at the Office of Integrated Access and Support makes the disability determination as part of the application process.

B. Level of Care

The child must require a level of care that is typically provided in a hospital, although the child does not have to be admitted, relocated nor have a history of admissions to a hospital. If the child requires a level of care that can be provided in a nursing facility, eligibility for the Katie Beckett benefit must be assessed under Chapter II, Section 67 of this manual.

C. Appropriateness of Community-Based Care

The child must be able to receive or currently be receiving appropriate care outside a hospital setting that provides that level of care.

D. Limits of Cost of Community-Based Care

The total annual cost to MaineCare for home care must be no greater than the amount MaineCare would pay for the child's care in an institution.

45.09 | ADMISSION ELIGIBILITY AND CONTINUING ELIGIBILITY CRITERIA FOR PSYCHIATRIC UNIT SERVICES-

Effective
9/28/09

Providers must maintain a member record for each member documenting the medical necessity for psychiatric unit services. Documentation must be available to the Department and its Authorized Agent. Members must meet all four (4) of the following criteria to be eligible for psychiatric unit services, and must continue to meet all four (4) of the following criteria in order to continue to be eligible for this service:

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45.09 ADMISSION ELIGIBILITY AND CONTINUING ELIGIBILITY CRITERIA FOR PSYCHIATRIC UNIT SERVICES (cont.)

Effective
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1. The member has a substantiated diagnosis found in the most current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM).
2. Treatment is medically necessary. Medical necessity must include one (1) or more of the following:
 - a. The member exhibits an immediate or direct threat of serious harm to self or there is a clear and reasonable inference of serious harm to self, where suicidal precautions or observations on a 24-hour/day basis are required. This behavior must require intensive psychiatric, medical and nursing treatment interventions on a 24-hour day basis.
 - b. The member is exhibiting an immediate or direct threat of serious harm to others or there is evidence for clear and reasonable inference of serious harm to others. This behavior must require intensive psychiatric, medical and nursing treatment interventions on a 24-hour/day basis.
 - c. The member is exhibiting an extreme disabling condition such that one cannot take care of self in a developmentally appropriate level or requires assistance beyond the home or residential setting. The member's symptoms must be of such severity that they require 24-hour/day intensive medical, psychiatric, and nursing services. Outpatient treatment would be clearly unsafe or is unavailable. A lower level of care is not available or would not be adequate to successfully treat those symptoms.
3. Age specific criteria:
 - a. For members under the age of twenty one (21) or adults with a legal guardian:
 - i. The member's family / guardian(s), where applicable and clinically indicated, are willing to actively participate throughout the duration of treatment.
 - ii. The services can reasonably be expected to improve the member's condition or prevent further regression so that inpatient services will no longer be needed.

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- b. For members age sixty five (65) or older, services are the only alternative available to maintain or restore the member to the greatest possible degree of health and independent functioning.
 - 4. A clear indication that the inpatient psychiatric services offered provide the member with active treatment.

45.10 REIMBURSEMENT

See Chapter III, Section 45, Principles of Reimbursement for Hospital Services.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of the rendered service prior to billing the MaineCare Program, including billing Medicare, as described under Title XVIII.

45.11 CO-PAYMENT FOR INPATIENT SERVICES, OUTPATIENT HOSPITAL CLINIC SERVICES

- A. A co-payment will be charged to each MaineCare member receiving either inpatient or outpatient hospital services. Two separate co-payments will be charged if the member receives both inpatient and outpatient services. The amount of the co-payment shall not exceed three dollars (\$3.00) per day for either category of hospital services provided, according to the following schedule:

MaineCare Payment for Service	Maximum Member Co-payment Per Day
\$10.00 or less	\$.50
\$10.01 - 25.00	\$1.00
\$25.01 - 50.00	\$2.00
\$50.01 or more	\$3.00

- B. The member shall be liable for co-payments up to a maximum of thirty dollars (\$30.00) per calendar month for each category: inpatient or outpatient service, and regardless of whether there are multiple hospital service providers within the same month. After the maximum thirty dollar (\$30.00) monthly cap(s) has been charged to the member, the member shall not be liable for additional co-payments and the provider(s) shall receive full MaineCare reimbursement.
- C. No provider may deny services to a member for failure to pay a co-payment. Providers must rely upon the member's representation that he or she does not have

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the cash available to pay the co-payment. A member's inability to pay a co-payment does not, however, relieve him/her of liability for a co-payment.

- D. Providers are responsible for documenting the amount of co-payments charged to each member (regardless of whether the member has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous co-payments.

Co-payment exemptions and dispute resolution procedures are contained in Chapter I.

45.12 BILLING INSTRUCTIONS

- A. For all inpatient services, providers must bill in accordance with the Department's billing requirements set forth in "Billing Instructions: Claim Form UB-92" or successor forms or instructions.
- B. For all services provided on or after September 1, 2007 by primary care practices that are considered Medicare provider based entities, providers must bill in accordance with the Department's billing requirements set forth in "Billing Instructions: Claim Form CMS-1500" or successor instructions.
- C. For all outpatient services, other than those identified in B above, providers may bill using either the UB-92 or successor form or the CMS-1500, in accordance with the applicable MaineCare billing instructions.
- D. Providers should request reimbursement for all services provided on the same day on the same claim form.
- E. Only providers that qualify as "provider based" entities under 42 CFR 413.65 may bill under this Section of the MaineCare Benefits Manual.
- F. Copies of MaineCare billing instructions may be downloaded at http://www.maine.gov/dhhs/oms/providerfiles/billing_instructions.html

45.13 REPORTING REQUIREMENTS

Hospitals must submit a quarterly list of National Drug Codes (NDC) for claims submitted on or after July 1, 2008 for the top 20 drugs on a list maintained by CMS. Hospitals eligible to purchase these drugs through Section 340B of the Public Health Service Act (referred to as 340 B hospitals) are exempt from this requirement. The list of Medicaid Top 20 Physician-Administered Multiple Source drugs can be found at the following CMS website: http://www.cms.hhs.gov/Reimbursement/15_PhysicianAdministeredDrugs.asp

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45.13 REPORTING REQUIREMENTS (cont.)

The quarterly report must be submitted within three months (or the first day thereafter) of the end of the calendar quarter in which the claim is filed. (e.g., Jan 1, 2009 for claims filed July 1, 2008 – Sep. 30, 2008) in accordance with the Department's billing instructions. The Department has determined that a failure to comply with this reporting requirement is a sanction, as defined in MBM, Chapter I, Section I, 1.19.

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Effective January 1, 2010, and until implementation of MaineCare's new claims system, MIHMS, hospitals shall report certain listed rebatable physician administered drugs by NDC. Drugs required for reporting will be listed at <http://mainecarepdl.org/index.pl/home/cms-rebatable-drugs2>. Effective upon the implementation of MIHMS, hospitals shall report all rebatable physician administered drugs by NDC. Hospitals will receive a thirty [30] day notice prior to MIHMS implementation. MaineCare will not pay for drugs that do not have a CMS rebate agreement unless they are medically essential and a PA has been approved.